OASIS ITEM:

(M0420) Frequency of Pain interfering with patient's activity or movement:

- ☐ 0 - Patient has no pain or pain does not interfere with activity or movement
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time

DEFINITION:

Identifies frequency with which pain interferes with patient's activities, with treatment if prescribed.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Responses are arranged in order of least to most interference with activity or movement.

ASSESSMENT STRATEGIES:

When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities, e.g., the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk.

Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain.

Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual analog pain scales.

The patient's treatment for pain (whether pharmacologic or nonpharmacologic treatment) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.

OASIS ITEM:

(M0490) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Never, patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

DEFINITION:

Identifies the patient's level of shortness of breath.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient usually uses oxygen continuously, mark the response that best describes the patient's shortness of breath while using oxygen.
- If the patient uses oxygen intermittently, mark the response that best describes the patient's shortness of breath WITHOUT the use of oxygen.
- The responses represent increasing severity of shortness of breath.

ASSESSMENT STRATEGIES:

Request to see the bathroom setup, allowing you the opportunity to observe and evaluate the occurrence of shortness of breath with a walk of a distance you can estimate (if less than 20 feet, ask the patient to extend the distance back to a chair). During conversation with the patient, does he/she stop frequently to catch his/her breath? Review symptoms and their severity in past health history.

OASIS ITEM:

(M0520) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[If No, go to *M0540*]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[Go to *M0540*]**

DEFINITION:

Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), mark Response 0.
- If the patient is incontinent AT ALL (i.e., “occasionally”, “only once-in-a-while”, “sometimes I leak a little bit”, etc.), mark Response 1.
- If the patient requires the use of a urinary catheter for any reason (retention, post-surgery, incontinence, etc.), mark Response 2.
- If the patient is both incontinent and requires a urinary catheter, mark Response 2 and follow the skip pattern.
- A leaking urinary drainage appliance is not incontinence.

ASSESSMENT STRATEGIES:

Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems.

OASIS ITEM:

(M0530)* When does **Urinary Incontinence** occur?

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - During the night only
- ☐ 2 - During the day and night

*At follow-up, following the item number (M0530) insert the phrase, "skip this item if patient has no urinary incontinence or has a urinary catheter."

DEFINITION:

Identifies the time of day when the urinary incontinence occurs.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If patient is only “occasionally” incontinent, determine when the incontinence usually occurs.
- Any incontinence that occurs during the day should be marked with Response 2.
- Insert directions at follow-up to skip this item if the patient has no urinary incontinence or has a urinary catheter.

ASSESSMENT STRATEGIES:

Once the existence of incontinence is known, ask when the incontinence occurs.

OASIS ITEM:

(M0670) Bathing: Ability to wash entire body. **Excludes grooming (washing face and hands only).**

Prior	Current			
☐	☐	0	-	Able to bathe self in shower or tub independently.
☐	☐	1	-	With the use of devices, is able to bathe self in shower or tub independently.
☐	☐	2	-	Able to bathe in shower or tub with the assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas.
☐	☐	3	-	Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
☐	☐	4	-	Unable to use the shower or tub and is bathed in bed or bedside chair.
☐	☐	5	-	Unable to effectively participate in bathing and is totally bathed by another person.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's ability to bathe entire body and the assistance which may be required to safely bathe in shower or tub. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- The patient who bathes independently at the sink must be assessed in relation to his/her ability to bathe in tub or shower. Is assistance needed for the patient to bathe in tub or shower? If so, what type of assistance?
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then Response 2 or Response 3 applies, depending on the quantity of assistance needed.
- If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been able to bathe self as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower if person or device is available to assist. Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower.

OASIS ITEM:

(M0690) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior	Current			
☐	☐	0	-	Able to independently transfer.
☐	☐	1	-	Transfers with minimal human assistance or with use of an assistive device.
☐	☐	2	-	Unable to transfer self but is able to bear weight and pivot during the transfer process.
☐	☐	3	-	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
☐	☐	4	-	Bedfast, unable to transfer but is able to turn and position self in bed.
☐	☐	5	-	Bedfast, unable to transfer and is unable to turn and position self.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's ability to safely transfer in a variety of situations. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient is able to transfer self, but requires standby assistance to transfer safely, or requires verbal cueing/reminders, then Response 1 applies.
- Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (e.g., a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).
- The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other, then Response 3 must be selected.
- If the patient is bedfast, the ability to turn and position self in bed is assessed.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about transferring ability. Observe the patient during transfers and determine the amount of assistance required for safe transfer. If ability varies between the transfer activities listed, record the level of ability applicable to the majority of those activities. When the patient demonstrates ambulation/locomotion, shows the clinician to the bathroom/kitchen, and demonstrates ability to get into and out of tub/shower, transferring can be assessed simultaneously.

OASIS ITEM:

(M0700) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current			
☐	☐	0	-	Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
☐	☐	1	-	Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
☐	☐	2	-	Able to walk only with the supervision or assistance of another person at all times.
☐	☐	3	-	Chairfast, unable to ambulate but is able to wheel self independently.
☐	☐	4	-	Chairfast, unable to ambulate and is unable to wheel self.
☐	☐	5	-	Bedfast, unable to ambulate or be up in a chair.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient requires standby assistance to safely ambulate or requires verbal cueing/reminders, then Response 1 or Response 2 applies, depending on the quantity of assistance needed.
- Responses 3 and 4 refer to a patient who is unable to ambulate, even with the use of assistive devices and assistance. A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 3 or 4, based on ability to wheel self.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently.

OASIS ITEM:

(M0780) Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Prior	Current			
☐	☐	0	-	Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
☐	☐	1	-	Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) given daily reminders; OR (c) someone develops a drug diary or chart.
☐	☐	2	-	Unable to take medication unless administered by someone else.
☐	☐	NA	-	No oral medications prescribed.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's ability to prepare and take oral medications reliably and safely and the type of assistance required to administer the correct dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- Exclude injectable and IV medications.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- Only medications whose route of administration is "po" should be considered for this item. Medications given per gastrostomy (or other) tube are not administered "po," but are administered "per tube."

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening medication containers. Ask the patient to state the proper dosage for each medication and the correct times for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item. If patient's ability to manage medications varies from medication to medication, consider total number of medications and total daily doses in determining what is true most of the time.

OASIS ITEM:

(M0830) Emergent Care: Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)**

- ☐ 0 - No emergent care services **[If no emergent care, go to M0855]**
- ☐ 1 - Hospital emergency room (includes 23-hour holding)
- ☐ 2 - Doctor's office emergency visit/house call
- ☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites)
- ☐ UK - Unknown **[If UK, go to M0855]**

DEFINITION:

Identifies whether the patient received an unscheduled visit to any (emergent) medical services other than home care agency services. Emergent care includes all unscheduled visits to such medical services. A "prn" agency visit is not considered emergent care.

TIME POINTS ITEM(S) COMPLETED:

Transfer to an inpatient facility - with or without agency discharge
Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS:

- If a patient went to the ER, was "held" at the hospital for observation, then released, the patient did receive emergent care.
- Exclude outpatient visits for scheduled diagnostic testing.
- Responses to this item include the entire period since the last time OASIS data were collected, including current events.

ASSESSMENT STRATEGIES:

Ask the patient/caregiver if the patient has had any services for emergent care. Clarify that a doctor's office visit for an emergent problem, which is scheduled less than 24 hours in advance, is considered an emergent care visit.

OASIS ITEM:

(M0855) To which **Inpatient Facility** has the patient been admitted?

- ☐ 1 - Hospital **[Go to *M0890*]**
- ☐ 2 - Rehabilitation facility **[Go to *M0903*]**
- ☐ 3 - Nursing home **[Go to *M0900*]**
- ☐ 4 - Hospice **[Go to *M0903*]**
- ☐ NA - No inpatient facility admission *

* At inpatient transfer, omit "NA."

DEFINITION:

Identifies the type of inpatient facility to which the patient was admitted.

TIME POINTS ITEM(S) COMPLETED:

Transfer to inpatient facility - with or without agency discharge
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Admission to a freestanding rehabilitation hospital or a rehabilitation distinct part unit of a general acute care hospital is considered a rehabilitation facility admission.
- Admission to a skilled nursing facility (SNF), an intermediate care facility for the mentally retarded (ICF/MR), or a nursing facility (NF) is a nursing home admission.

ASSESSMENT STRATEGIES:

Often the family or medical service provider informs the agency that the patient has been admitted to an inpatient facility. Clarify with this informant as to which type facility the patient has been admitted. As a last resort, you may have to contact the facility to determine how it is licensed.

OASIS ITEM:

(M0870) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

- ☐ 1 - Patient remained in the community (not in hospital, nursing home, or rehab facility)
- ☐ 2 - Patient transferred to a noninstitutional hospice **[Go to *M0903*]**
- ☐ 3 - Unknown because patient moved to a geographic location not served by this agency **[Go to *M0903*]**
- ☐ UK - Other unknown **[Go to *M0903*]**

DEFINITION:

Identifies where the patient resides after discharge from the home health agency.

TIME POINTS ITEM(S) COMPLETED:

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Patients who are in assisted living or board and care housing are considered to be living in the community.
- Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.

ASSESSMENT STRATEGIES:

At agency discharge, determine where the patient will be living/residing.

OASIS ITEM:

(M0100) This Assessment is Currently Being Completed for the Following Reason:

Start/Resumption of Care
- ☐ 1 – Start of care—further visits planned
- ☐ 3 – Resumption of care (after inpatient stay)

Follow-Up
- ☐ 4 – Recertification (follow-up) reassessment **[Go to *M0175*]**
- ☐ 5 – Other follow-up **[Go to *M0175*]**

Transfer to an Inpatient Facility
- ☐ 6 – Transferred to an inpatient facility—patient not discharged from agency **[Go to *M0830*]**
- ☐ 7 – Transferred to an inpatient facility—patient discharged from agency **[Go to *M0830*]**

Discharge from Agency — Not to an Inpatient Facility
- ☐ 8 – Death at home **[Go to *M0906*]**
- ☐ 9 – Discharge from agency **[Go to *M0200*]**

DEFINITION:

Identifies the reason why the assessment data are being collected and reported. Accurate recording of this response is important as the data reporting software will accept or reject certain data according to the specific response that has been selected for this item.

TIME POINTS ITEM(S) COMPLETED:

All

RESPONSE—SPECIFIC INSTRUCTIONS:

- Mark only one response.
- Response 1: This is the start of care comprehensive assessment. A plan of care is being established, and further visits are planned.
- Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer (for reasons other than diagnostic tests). Remember to update the Patient Tracking Sheet ROC date (M0032) when this response is marked.
- Response 4: This comprehensive assessment is conducted during the last five days of the 60-day certification period.
- Response 5: This comprehensive assessment is conducted due to a significant change (a major decline or improvement) in patient condition at a time other than during the last five days of the episode. This assessment is done to update the patient's care plan.